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AUTHOR Ogden, Horace G.
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ABSTRACT

The author, Director of the Bureau of Health Education, Center for Disease Control, discusses (1) an emerging shift in government policy from treatment to prevention in matters of health; (2) the need for developing a definition of reasonable expectations upon which to base health education efforts; and (3) three general interests at the national level which are receiving high priority attention--the immunization of children, a campaign against smoking, and a reduction in unwanted pregnancies, especially among adolescents. (MJB)

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Issues and Challenges in Health Education

for Presentation at American School Health Association

Atlanta, October 14, 1977

I'm honored and pleased to have this opportunity to discuss issues and challenges in health education with the American School Health Association. We have plenty of both--issues and challenges--before us, and I am convinced that we will greatly enhance our chances of meeting them by bringing the education and health establishments together, at every level and at every appropriate moment.

Incidentally I am also honored to be appearing with Mr. Johnson and Dr. Simonds, and particularly pleased to be batting leadoff. I've been on panels with both of these gentlemen before--in fact we form a part of a sort of permanent floating vaudeville tour--and I know from experience that each of them is a hard act to follow.

Let me begin, then, with a brief review of recent events in the health education field as seen from my particular vantage-point on the health side of the Federal enterprise. That sentence carries with it two important caveats. First, the view from any Federal window tends to be curiously foreshortened and seen through tinted glass: it magnifies events at the governmental level at the expense of events where the action really is, in the states and communities. Second, each Federal agency tends to have its own parochial interests, and the Public Health Service is certainly not immune to that problem.

Horace G. Ogden, Director, Bureau of Health Education, Center for Disease Control, PHS-DHEW, Atlanta, Georgia 30333

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Nevertheless, I think it's true from any perspective that events in the recent past have created a new context for issues and challenges in health education--the kinds of issues and challenges that health educators and their associates have been debating among themselves for years. In bygone days--indeed not long by-gone--discussion of such issues has been largely an academic exercise. Now, rather suddenly, there are policies to be developed in the context of reality--the heartwarming context that resources may become available with which those policies can begin to be carried out.

The most widely visible of the events creating this new context have been in the area of health legislation. Successively the Congress has written new charters for the National Cancer Institute and the National Heart, Lung and Blood Institute mandating major attention to prevention, education and control in parallel with their traditional biomedical research missions. The new Diabetes Act puts similar stress on preventive aspects.

In 1975 Congress enacted Public Law 93-641, the Health Planning and Resource Development Act, which restructured and reconstituted the health planning system and, significantly for our purposes here, made very explicit inclusion of prevention and health education among the responsibilities of the new Health Systems Agencies.

Then in 1976, the Congress enacted and the President signed Public Law 94-317, the Consumer Health Information and Health Promotion Act, which codified and pulled together a broad range of preventive educational and promotive health authorities. Many of these authorities already existed, piecemeal, in various sections of the basic Public Health Service Act. The

primary significance of Public Law 94-317 is that it creates a new Title XVII of the Public Health Service Act specifically devoted to educational and promotional activities related to health. It mandates the creation of a new Office of Health Information and Health Promotion within the Office of the Assistant Secretary for Health, which has been done. It authorizes substantial new sums of money, only a small part of which have been appropriated.

Notably, and lamentably, there have not been similar legislative events having direct impact in school health education. But I think that you will be increasingly partaking of this new wave of interest.

Along with these legislative activities, already cited there have been other developments at the Federal level worthy of mention. The work of a President's Committee on Health Education, appointed with little fanfare in 1971 and whose report was received with even less fanfare in 1973, led directly to the establishment of a Bureau of Health Education at the Center for Disease Control in 1974 and indirectly, in part through the Bureau's initial support, to the creation of a private sector-based National Center for Health Education which became operational in 1976.

Finally, prevention and health education have once again become acceptable--almost obligatory--subjects for discourse by statesmen in and outside the field of health. At the APHA meeting in Miami in October 1976, then-candidate Jimmy Carter made a powerful and persuasive statement of the importance of prevention. Secretary Joseph Califano of HEW, in the very early days of his tenure, has stressed immunization as an immediate priority, has

made the strongest statements on cigarette smoking issued by a person in that office since its establishment in 1953, and has identified education as an important instrument for dealing with the serious health and social consequences of unwanted pregnancies, especially among adolescents. I shall return to these priorities a little later.

Thus, after languishing in comparative obscurity for many years, the concepts of health education and prevention, like Ko-Ko in Gilbert and Sullivan's Mikado, have been "taken from the county jail by a set of curious chances." There is a law on the books, duly passed by the Congress and signed by the President, mandating a great many things that health educators have wanted to do for a long time. Leaders in the health field, both in and out of government, are proclaiming health education among their high priorities.

This is bright sunlight for a group emerging from the catacombs. In adjusting, it is necessary to look realistically at how the change took place.

The sudden emergence of health education as a high priority item is not based on a convincing demonstration that health education works. In my view it is based on two fundamental factors, neither of which has very much to do with the track record of education related to health.

The first factor is a very widespread and rapidly growing dissatisfaction with the results of enormous expenditures on therapeutic medicine. People see more and more billions of dollars being poured into health care

every year, with no end in sight. And at the same time they do not perceive any significant improvement in the nation's health. Whether or not this indictment is fair is beside the point. The significant fact is the disenchantment itself.

The second factor, derived from the first, is an elaboration of the old saw that an ounce of prevention is worth a pound of cure. Health educators benefit from an alluring line of logic. The individual is the primary agent in his own health behavior; therefore, he needs to be equipped to act wisely both in health and in sickness; therefore, health education is good for him and for the society of which he is a part.

There is nothing wrong with this logic. The inherent danger lies in putting together the two factors just cited and basing expectations on them. If we encourage - or even allow - acceptance of the proposition that health education is <u>the</u> answer to the ills of the health care system and the people it seeks to serve, and to the escalating costs thereof, we are extremely likely to reap our own harvest of disenchantment a few years down the road.

Therefore, I propose as a first issue for policy development the <u>definition of reasonable expectations.</u> What are the maximum feasible goals that health education can be rationally asked to accomplish in two years, or five years, or twenty? The specifics of this question will obviously vary depending on the setting -- school, hospital, community, etc.-- and on the subject matter. But regardless of these differences, to address this issue we need to make some assumptions and devise measuring-rods for accomplishment.

Are we talking about "X" percent reduction in mortality and morbidity rates

from certain specified conditions? Are we talking about progress on a not-yet-defined index of wellness? Can we really talk about cost-containment at all, and if so, how much, how measured? Are we talking about all of the above? Or are we talking about something much more modest, such as attitudinal or even behavioral change -- which really aren't modest at all, but are certainly easier to handle than morbidity and mortality rates and cost containment which depend on many factors far beyond the control of health education? Perhaps we should be aiming for some sort of functional health literacy level. In any case, we need to define what we are trying to accomplish.

Clearly, no sensible consideration of reasonable expectations can be conducted without some assumption about the resources available. For each rational goal we need to project a time-scale and also a resource scale. What can society expect along these various axes with an investment of "X" dollars? 2X? 10X?

Finally, in discussing the issue of reasonable expectations, we need to confront those ever-present questions of cost benefit and cost effectiveness. In dealing with these contemporary divining-rods, it is necessary to force the question, "Compared to what?" If the resources and efforts expended in health education are the numerator in these cost fractions, what is the denominator?

Even in programs in which measurements of achievement are relatively easy to define, as for example in an immunization campaign, the cost benefit and effectiveness of the total program is difficult to pinpoint and that of the educational component more difficult still. Consider a program which raised the measles immunization levels of given cadre of children from 60 percent to 90 percent. One can compute the number of cases of

measles that would have occurred, but presumably will not, as a result of this major effort. (Note "presumably"; we will have to wait several years to know if they actually do not occur.) From this we can compute the number of school days' actual attendance that would have been lost (What price a school day?); the number of cases that would have led to severe disabilities, including deaths; and so on. Then, with a numerator and a denominator, we can come up with a reasonably respectable estimate of cost benefit for the campaign as a whole. But what was the cost effectiveness of the educational component? How much of the increase from 60 percent to 90 percent in immunization levels resulted from what was done under the banner of education/communication?

So much for the easy problems. How about the really tough ones? Can sex education programs for 11 to 15-year-olds, introduced through the schools or through religious organizations, youth groups or whatever, really be expected to reduce the number of unwanted pregnancies? Is this the yardstick by which such programs shall be measured? If not, what can be expected of effective sex education programs? How shall they be made accountable?

Similarly, on a still broader base, what reasonable expectations can we ascribe to a non-categorical, generic health education program in schools? To cite one example with which I am personally familiar, the School Health Curriculum Project, often known as the "Berkeley Project", has been underway for nearly a decade, first under the sponsorship of the National Clearinghouse for Smoking and Health and more recently of the Bureau of Health Education. It is now operative in over 300 school districts in 35 States. Its avowed purpose has been to help young people understand how their body systems work and how their decisions -- in terms largely of lifestyle choices -- affect their health. It has been received

enthusiastically by kids, teachers, administrators, parents, and a variety of local and national agencies.

But what does it really do? Do kids who have been through the Berkeley Curriculum from the 3rd through 7th grades really smoke less, drink less, eat less junk food five years later than their contemporaries who didn't have the benefit of the project? We're trying now to find out. The point here, however, is not whether they do or don't, but whether this is a reasonable expectation. Suppose, for example, that they are not significantly better able to resist peer pressures at age 17, but more likely to quit smoking at age 22? Suppose their lifestyle cannot be demonstrated to be different, but more of their parents gave up smoking because the kids nagged them to death during the Berkeley experience? Will we be able to detect such fringe benefits? Can we justifiably claim credit for them?

The ultimate object of a specific preventive program is usually the reduction of morbidity and mortality. Health education in its various manifestations can be, indeed should be, a very important part of a continuum of processes leading to this achievement. But an excellent health education component, in and of itself, cannot guarantee the success of the total process; not, to be entirely honest, does the absence of a good health education component necessarily predetermine failure.

This is not to suggest that we need to go into another orgy of definition, of building walls around what is health education and what is not. We've done enough of that. It does suggest, however, that we need to be realistic in our promises, honest in our claims of success. Above all it suggests that we need to refine our instruments for measuring and documenting what health education acutally accomplishes. The refinement of measures may well be one of the most critical research needs of the next decade.

Finally, underlying these issues of implementation of practice, there is the eternal challenge of support for health education programming. Despite the soaring rhetoric; despite the enactment of new legislation, the creation of new offices and bureaus carrying the banner of health education or health promotion in their titles; and no matter how we may deplore it: the fact remains that funding for educational activities with respect to health continues predominantly to come with strings attached, earmarked for quite specific categorical purposes.

Deplore it we may. Live with it and indeed take advantage of it we must. It becomes increasingly apparent that success lies in creating frameworks within which new initiatives, new emphasis can fit and prosper. Where such frameworks, or managerial models, exist, new quanta of subject matter accompanied by new quanta of resources represent not a disruption but an opportunity.

As I have mentioned, there are at least three clearly discernible major interests at the national level, none of them new but all of them ready for high priority attention. They have been identified by the new leadership in HEW as matters of immediate and urgent concern. Task forces and work groups that cut across traditional agency lines are planning approaches and identifying resources--present and future--to deal with them. The three are (1) a renewed commitment to immunization of all children, (2) an intensified interest in reducing the damage done by smoking, and (3) a many-dimensional effort to address the problem of unwanted pregnancies, especially among adolescents.

It is self-evident that each of these problems has implicit and critically important educational implications. Each depends absolutely upon educated behavior on the part of individual adults and young people. Each requires

the imparting of information, the dispelling of misinformation, the formation or transformation of attitudes and decisions, the motiviation to act upon those decisions. Each requries also the fostering of a social climate which encourages and supports these individual decisions.

These requirements for success are at the very heart of the educational process in health. They are right on the street where we live. How shall we respond?

One way is to stand with our buckets and hope to be in the right place when the new faucets in the sky are turned on. Another way is to assess the needs and existing resources in these areas on our own local scene, determine realistically what can be done and what we can contribute, and get something going. For neither all wisdom nor all resources trickle downward from Federal spigots, nor does all responsibility reside at national levels.

The several dozen relevent Federal funding programs, both for disease control and for provision of services, will basically continue to march to their several different drummers. The coordinating mechanisms -- including the Office of Health Information and Health Promotion, the Bureau of Health Education and the interagency groups created for specific purposes -- will do what they can to encourage cohesive effort. I am personally very much encouraged by the degree of interaction between health and education counterfacts in HEW that is now taking place as a result of these new initiatives, and equally by efforts such as those in Florida, the State of Washington and elsewhere to bring those establishments together at the State level.

But health education is a peculiarly local affair. Its national policy issues must be resolved where the people are, and its implementation issues settled where the work is done.